What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

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WHERE THE CH*i*PS FALL…

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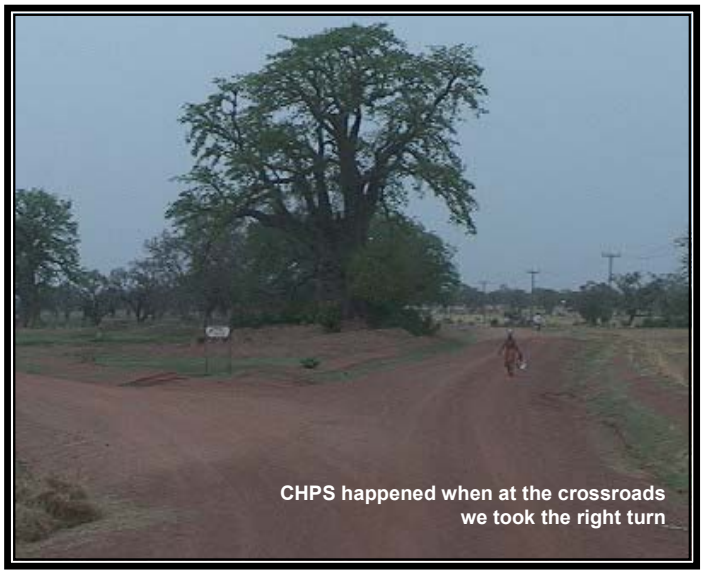
Generally, what has been the health system's response to CHPS?

I would say, great. When the Navrongo findings came out the health system immediately recognized that this was a key strategy for addressing an age-old problem of poor access to health care for rural communities. CHPS has been recognised as a pro-poor strategy for addressing health equity issues and this has resonated through the health system. That probably explains why as a national policy we seem to be pushing it too hard.



CHPS happened when at the crossroads we took the right turn

The Northern region has organised a conference to assess the state of CHPS implementation. Is that your idea of the way forward?

Admittedly so. CHPS is a district-level issue that needs support and guidance from the regional level and that is what the northern region is doing. There is the need for continuous dialogue among the districts in every region aided by the regional directorate. This enables skills and innovations to be shared and best practices adopted. The region also gets to know the hot spots and if there is the need to shift focus and or resources to make things move, this is quickly arranged.

What is the strategy for helping the 'laggards' in the CHPS process?

The CHPS M&E results indicate that 106 districts report that they have started CHPS. But for us we talk of completed CHPS zones. It is only a completed zone which can start delivering services because it will have gone through all the steps. Currently there are only 48 completed CHPS zones. Over 1,096 zones have been demarcated and are at various stages of getting started. We have observed that when a district completes one CHPS zone and it becomes functional, the tendency to move faster into other zones and starting CHPS is so great. So what we are doing is to bring those that are doing particularly well to come and tell their story of how they are making it. This is what has brought about the concept of 'Innovator Districts'. One innovator district has been identified from every region and these have been brought together to document their stories. We are also using the yearly national health forum to reach out to all districts and share ideas for moving forward.

What are some of the monitoring tools used by the PPME in the CHPS process?

Well, the most comprehensive one is the 90-day cycle collection of data from the districts. This is a set of questionnaires that districts fill in and submit to the PPME Secretariat. These are analysed and give us a fair indication of how things are on the ground. This is complemented by a field team that visits trouble spots to study the situation and submit reports. We do an average of two regions per quarter which is not enough. When we analyse the data we upload the results onto the CHPS website www.ghana-chps.org then copy the same information onto CD-ROMs and pass them around to all districts so that everyone has an idea of what others are doing. So far, that is the system in place and everything appears to be working just fine.

Are the reports submitted by districts always a true reflection of the situation on the ground?
It may be difficult to say that step two or three in this district has not been followed. Our monitoring system is not that of policing but of supporting. The team is able to spot some inconsistencies in reporting and help correct them. For instance, an entire region reported that almost all their districts had started CHPS. But the monitoring team realised that where a community-based surveillance system was in place they called it CHPS. We said, according to the definition, this couldn't be called CHPS. We managed to correct such misleading impressions and moved on.


The cold chain is crucial in the CHO's list of essential logistics

What will you call 'essential logistics' for a CHO going on posting to a community?
A short list of basic personal logistics include: cooking utensils, stoves, radio, living room furniture, including beds. When it comes to the service delivery aspect the motorbike is key; the cold chain equipment system whereby we have the kerosene fridges for storage of vaccines and then the ice chest that the nurse takes around. And of course, a BP apparatus. These are the basic items for service delivery. We are in the process of getting a comprehensive list of essential logistics based on the minimum equipment that districts are presently using.

Have you identified some innovations in some districts that can be replicated in other districts?
I should think so. One clear example is getting resources to construct Community Health Compounds (CHC). Some districts have been able to engage the district assemblies to use the HIPC funds to put up CHC. Others have linked up with NGOs and development partners to assist in this direction. A group of districts have succeeded in convincing communities to give up old buildings such as post offices for renovation into CHC. Some districts have developed forms for referral cases for the CHO. As the CHO goes on her daily rounds and comes across cases that she cannot deal with, she refers to the next level. Since the referral points recognize these forms, the bearers are given prompt attention. Patients and clients have begun to trust the system—they are referred by a CHO at the community level and when they arrive at the referral point they are given special treatment. These are a few creative ways of delivering service that clearly, others can emulate.

Any frustrations?
Many! But I have my eyes permanently fixed on the future. So my frustrations don't easily get on the way. Our service delivery strategy is gaining national and international recognition by the hour. Geographical access to health care services has been largely bridged and community members across the country continue to testify to the crucial role of the resident nurse. Our documentation resources, *What works? What fails?* and *Putting Success to Work,* have endeared CHPS to a respectable domestic and global audience. I feel a certain weight of responsibility to make the process work well. The health systems in most of our neighbouring countries have failed. In several instances the infrastructure has been devastated. Together, these have compounded the problems of deplorable access to health care for millions of rural people in the sub region. Do these people know that there is a strategy across the border that might work for them? I feel it is part of our responsibility to sell our product to our neighbours. When I view the happiness I enjoy in being part of the process of making this come true, my frustrations pale into insignificance.

Now you mention 'What works? What fails?'. Have you identified any gaps in the series that need to be filled?
As a matter of fact the series is working well. It's a simple two-page document that does not have to take too much of your time to read. I think that was the whole idea behind its development—to make it simple and attractive. The gaps have to do with the new things coming up in all the districts all over the country that *What works? What fails?* is not capturing. That is why we are encouraging other districts to have their own newsletter series to document their work and also share experiences on what they are doing.

Send questions or comments to: What works? What fails?
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